cash disbursements, payroll, general journal, resident census records identifying the level of care of all residents individually, all records pertaining to private pay residents and resident trust funds.

(b) To support allowable costs, the provider must make available for audit at the facility all business records of any related party, including any parent or subsidiary firm, which relate to the provider under audit. To support allowable costs, the provider must make available at the facility for audit any owner's or related party's personal financial records relating to the facility. Any costs not so supported will not be allowable.

(c) Cost information and documentation developed by the provider must be complete, accurate and in sufficient detail to support payments made for services rendered to recipients and recorded in such a manner to provide a record which is auditable through the application of reasonable audit procedure. This includes all ledgers, books, records and original evidence of cost (purchase requisitions, purchase orders, vouchers, checks, invoices, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost. The provider must make and maintain contemporaneous records to support labor costs incurred. Documentation created after the fact will not be sufficient to support such costs.

(d) The provider must make all of the above records and documents available at the facility at all reasonable times after reasonable notice for inspection, review or audit by the department or its agents, the federal department of health and human services, the Montana legislative auditor, and other appropriate governmental agencies. Upon refusal of the provider to make available and allow access to the above records and documents, the department may recover, as provided in ARM 37.40.347, all payments made by the department during the provider's fiscal year to which such records relate.

(6) Department audit staff may perform a desk review of cost statements or reports and may conduct on-site audits of provider records. Such audits will be conducted in accordance with audit procedures developed by the department.

(a) Department audit staff may determine adjustments to cost reports or reported costs through desk review or audit of cost reports. Department audit staff may conduct a desk review of a cost report to verify, to the extent possible, that the provider has provided a complete and accurate report.

(b) Department audit staff may conduct on-site audits of a provider's records, information and documentation to assure validity of reports, costs and statistical information. Audits will meet generally accepted auditing standards.

(c) The department shall notify the provider of any adverse determination resulting from a desk review or audit of a cost report and the basis for such determination. Failure of the department to complete

a desk review or audit within any particular time shall not entitle the provider to retain any overpayment discovered at any time.

(d) The department, in accordance with the provisions of ARM 37.40.347, may collect any overpayment and will reimburse a provider for any underpayment identified through desk review or audit.

(e) For providers receiving per diem rates determined in accordance with ARM 37.40.313 and 37.40.314, if based upon desk review or audit of the provider's base period cost information used to determine the per diem rate, the department adjusts such costs upward or downward, the department shall adjust rates retroactively for the period of the per diem rate in accordance with adjusted costs and shall use adjusted cost information in any subsequent calculations for which such base period cost information is used. The provider shall not be entitled to any adjustment until the department has mailed notice of final settlement to the provider. Any overpayment or underpayment shall be paid or collected in accordance with the cost settlement procedures in ARM 37.40.347.

(7) A provider aggrieved by an adverse department action may request administrative review and a fair hearing as provided in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 2000 MAR p. 492, Eff. 2/11/00; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

37.40.347 COST SETTLEMENT PROCEDURES (1) The department will notify the provider of any overpayment discovered. The provider may contact the department to seek an agreement providing for repayment of the full overpayment within 60 days of mailing of the overpayment notice.

(2) Unless, within 30 days of mailing of overpayment notice to the provider, the provider enters into an agreement with the department which provides for full repayment within 60 days of mailing of the overpayment notice, the department will immediately commence offsetting from rate payments so as to complete full recovery as soon as possible.

(3) The department may recover the full overpayment amount regardless of whether the provider disputes the department's determination of the overpayment in whole or in part. A request for administrative review or fair hearing does not entitle a provider to delay repayment of any overpayment determined by the department.

(4) The department will notify the provider of any underpayment discovered. In the event an underpayment has occurred, the department will reimburse the provider promptly following the department's determination of the amount of the underpayment.

(5) Court or administrative proceedings for collection of overpayment or underpayment must be commenced within 5 years following the due date of the original cost report or the date of receipt of a complete cost report whichever is later. In the case of a reimbursement or payment based on fraudulent information, recovery of overpayment may be undertaken at any time.

(6) The amount of any overpayment constitutes a debt due the department as of the date the department mails notice of overpayment to the provider. The department may recover the overpayment from any person, party, transferee, or fiduciary who has benefitted from either the payment or from a transfer of assets. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; TRANS, from SRS, 2000 MAR p. 489.)

Rules 48 through 50 reserved

37.40.351 THIRD PARTY PAYMENTS AND PAYMENT IN FULL

(1) Regardless of any other provision of these rules, a provider may not bill the medicaid program for any patient day, item, service or other amount which could have been or could be paid by any other payer, including but not limited to a private or governmental insurer, or medicare, regardless of whether the facility participates in such coverage or program. If the department finds that medicaid has made payments in such an instance, retroactive collections may be made from the provider in accordance with ARM 37.40.347.

(a) This rule does not apply to payment sources which by law are made secondary to medicaid.

(2) The payments allowed under ARM 37.40.307 constitute full payment for nursing facility services and separately billable items provided to a resident. A provider may not charge, bill or collect any amount from a medicaid recipient, other than the resident's patient contribution and any items billable to residents under ARM 37.40.331.

(3) This rule applies in addition to ARM 37.85.415. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.352 UTILIZATION REVIEW AND QUALITY OF CARE

(1) Upon admission and as frequently thereafter as the department may deem necessary, the department or its agents, in accordance with 42 CFR 456 subpart F (1997), may evaluate the necessity of nursing facility care for each medicaid resident in an intermediate care facility for the mentally retarded. 42 CFR 456 subpart F contains federal regulations which specify utilization review criteria for intermediate care facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456 (1997). A copy of these regulations may be

obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-142, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

Rules 53 through 59 reserved

37.40.360 LIEN AND ESTATE RECOVERY FUNDS FOR ONE-TIME EXPENDITURES (1) A one-time appropriation by the 1999 Montana legislature allowed the department to allocate funds from its lien and estate recovery program to the medicaid nursing home program. By the terms of the appropriation, the funds must be used for nursing home staff training, bonuses for direct care staff or one-time benefits for staff.

(2) The department will allocate to each certified nursing facility located within the state of Montana its pro rata share of the total appropriated funds, computed as provided in (3), which submits a qualifying request which is approved by the department. The funds are subject to availability and are a one-time appropriation to the nursing home program to be used only for staff training, bonuses for direct care staff or for other one-time benefits for staff.

(3) The department shall distribute the funds on the basis of medicaid utilization at each nursing care facility. The amount payable to each facility shall be the pro rata share of total available appropriated funds available based upon collections prior to the end of the state fiscal year ending June 30, 2000 and in subsequent fiscal years. The amount of funds distributed and payable to each facility shall be computed by dividing the total amount of funds available by the total number of medicaid days occupied in the fiscal year for all facilities, to arrive at a per medicaid day amount. Each facility's share will be calculated by multiplying the facility's number of occupied medicaid days for that period by the per day medicaid amount.

(4) To receive funds under this rule, a nursing care facility shall submit, and have approved, a request form to the department, which specifies how the facility will use these funds for one-time expenditures for staff training, bonuses for direct care staff or for other one-time benefits for staff. The department will review each request and approve qualifying requests prior to making payment. If the cost of a proposal approved by the department exceeds the amount of funds payable to that facility, the department shall not be obligated to and will not reimburse the facility any more than its pro rata share of the available funding.

(5) Facilities that do not submit a qualifying request by the deadline established by the department, shall have their pro rata share

of the funds distributed to all other facilities that have submitted a qualifying and approved request for these funds.

(6) A facility that receives funds under this rule shall maintain appropriate records documenting the expenditure of the funds. The documentation shall be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable medicaid record requirements, including but not limited to ARM 37.40.345, 37.40.346 and 37.85.414.

(7) The funds distributed under this rule are for one-time expenditures; and facilities will be required to offset these expenditures with the revenue received only under this rule on their annual cost report to the department. These expenses shall not be considered base period costs for the participating facilities. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489.)

37.40.361 ADDITIONAL PAYMENTS FOR DIRECT CARE WAGE AND BENEFITS INCREASES (1) A one-time appropriation by the 1999 Montana legislature authorized the department to distribute to facilities an additional amount for wage and benefits increases for direct care workers in nursing homes.

(2) The department will pay medicaid certified nursing care facilities located in Montana who submit an approved request to the department, an additional amount, computed as provided in (3), as an add-on to their computed medicaid payment rate to be used only for wage and benefit increases for direct care workers in nursing homes.

(3) The department will determine a per day add-on payment, commencing July 1, 1999 and at the beginning of each state fiscal year thereafter, as a pro rata share of appropriated funds allocated for increases in direct care wages and benefits.

(4) To receive the direct care add-on, a nursing facility shall submit for approval a request form to the department which indicates how the direct care add-on will be spent in the facility. The facility shall submit all of the information required on a form to be developed by the department in order to continue to receive the additional add-on amount for the entire rate year. The form will request information including but not limited to, the number of FTE's employed by category of authorized direct care worker that will receive the benefit of the increased funds, current per hour rate of pay with benefits for each category of worker, projected per hour rate of pay with benefits after the direct wage increase has been implemented, number of staff receiving a wage or benefit increase by category of worker, effective date of implementation of the increase in wage and benefit, and number of projected hours to be worked in the budget period.

must be received by the department within the period of any previous extension, and must demonstrate good cause for the extension.

(b) The provider may also request a conference as part of the administrative review. If the provider requests an administrative review conference, the conference must be held at a time scheduled by the department as provided in ARM 37.5.318(3) through (3)(c)(ii). If a provider requests a conference as part of the administrative review, any substantiating materials the provider wishes the department to consider as part of the review may be submitted no later than the time of the conference. The conference may be conducted by the department or its designee and shall be based on the department's records and determination and the provider's written objections and substantiating materials, if any.

(c) No later than 60 days following receipt of the written objections and substantiating materials, if any, or the conference, whichever is later, the department must mail a written determination concerning the provider's objections and substantiating materials and the position the department takes concerning the determination.

(d) A provider must exhaust in a timely manner the administrative review process provided in this rule before requesting a fair hearing. A provider that has not exhausted the administrative review process, including a provider that fails to timely request an administrative review, is not entitled to a fair hearing before the department or the board.

(3) In the event the provider is aggrieved by an adverse department administrative review determination, the following fair hearing procedures will apply. In addition to the authority granted in ARM 37.5.313, the hearings officer may dismiss a fair hearing request if a provider fails to meet any of the requirements of (3)(a) through (3)(e).

(a) The written request for a fair hearing must be mailed or delivered to the Department of Public Health and Human Services, Quality Assurance Division, Office of Fair Hearings, P.O. Box 202953, Helena, MT 59620-2953.

(b) The request must be signed by the provider or his designee.

(c) The fair hearing request must be received not later than the 30th calendar day following the date of mailing of the department's written administrative review determination.

(d) The fair hearing request must contain a short and plain statement of each reason the provider contends the department's administrative review determination fails to comply with applicable law, regulations, rules or policies.

(e) The provider must serve a copy of the hearing request upon the department's division that issued the contested determination within 3 working days of filing the request. Service by mail is permitted.

(f) The hearings officer will conduct the fair hearing in accordance with the applicable provisions of this subchapter at Helena, Montana. The hearing shall be in person except that the hearing may be conducted by telephone as mutually agreed by the parties.

(g) The hearings officer will render a written proposed decision within 90 calendar days of final submission of the matter to him.

(4) In the event the provider or department is aggrieved by a hearings officer's proposed decision, the provider or department may request review by the board of public assistance as provided in ARM 37.5.331.

(5) The provisions of this rule apply in addition to the other applicable provisions of this subchapter, except that the provisions of this rule shall control in the event of a conflict with the other provisions of this subchapter. (History: Sec. 2-4-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-2-606, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1992 MAR p. 1496, Eff. 7/17/92; AMD, 1993 MAR p. 3069, Eff. 1/1/94; AMD, 1994 MAR p. 1744, Eff. 7/1/94; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

ATTACHMENTS

DIRECT CARE WAGE ADD-ON FORM FY2001

MARC RACICOT
GOVERNOR

LAURIE EKANGER
DIRECTOR

STATE OF MONTANA

PHONE: (406) 444-4077

SENIOR & LONG TERM CARE DIVISION
PO BOX 4210
HELENA, MT 59604-4210

July 26, 2000

TO: Nursing Facility Administrators
Association Representatives

FROM: Kelly Williams, Chief
Nursing Facility Services Bureau

SUBJECT: Direct Care Wage and Benefit Increases Fiscal Year 2001

The 1999 Montana legislature authorized DPHHS to distribute to nursing facilities an additional amount for wage and benefit increases for direct care workers. These funds are to be utilized by facilities to provide for increased wages or benefits for direct care staff, especially those staff that have hands-on care responsibilities with residents and who traditionally earn lower wages or are hard to retain because of the wage scales that are traditionally paid.

The fiscal year 2001 pro rata amount of the direct care add-on has been computed at $2.23 per Medicaid day effective July 1, 2000. The fiscal year 2000 amount was $2.14 per Medicaid day effective July 1, 1999. The Department has developed a form for use by nursing facility providers to document the way in which they will distribute this increase in funding to direct care workers. The categories of workers that can be considered as direct care has been broadly defined, in order to encourage flexibility in the distribution of these wage funds to the staff that are in the most need of a wage increase.

Attached is a listing, by facility, of the projected Medicaid days for fiscal year 2001 multiplied by the $2.23 per Medicaid day add-on that has been included in the facility per diem payment rate for July 1, 2000. The fiscal year 2000 days multiplied by the $2.14 per Medicaid day add-on that was included in the nursing facility per diem payment rate on July 1, 1999 was also included.

This information is provided so that each facility can determine the **annualized** amount of funding that should be distributed during fiscal year 2001 as direct care wage and benefit increases. If the facility provided direct care wage increases in fiscal year 2000, the starting wage effective July 1, 2000 should include this increase and the additional funds of $2.23 times the Medicaid days for the fiscal year are the additional direct care wage increases that must be documented for fiscal year 2001. The attached form indicates the type of information that we are requiring in order to document that the direct care wage add-on is being distributed in the manner designated by the legislature and in the amount that is estimated to be available to each facility.

NOTE: If you are distributing these funds as part of a bonus or incentive plan rather than increases in wages to staff, you must document the type of plan you are implementing, the number and type of staff that are impacted, as well as, provide ongoing documentation each time a distribution is made during the fiscal year in order to document that the total funding will be distributed through the bonus/incentive program. If you distributed last year's funds as a bonus/ incentive, please remember that the total amount of funding that you must document as distributed in fiscal year 2001 is $4.37 (2.14+2.23).

Please make copies of the form, if necessary, in order to provide the documentation which shows that the annualized amount of funding available will be distributed for the intended purpose of providing increases in wages and benefits for direct care workers. If you have other forms or types of documentation that support the distribution of the funds that are estimated to be paid to your facility over the next fiscal year for wage and benefit increases please feel free to attach this supporting documentation to the form. Providers that do not choose to participate or do not submit the completed form will have the $2.23 per diem amount recovered from their payments retroactively.

Please submit your completed form and signed certification to the Department of Public Health and Human Services, Senior and Long Term Care Division, P O Box 4210, Helena, MT 59604-4210, **on or before September 30, 2000.** If you have any questions please contact me at (406) 444-4147 or Steve Blazina at (406) 444-4129.

I. EXPLANATION AND INSTRUCTIONS

Intent: The 1999 Montana legislature authorized the Department of Public Health and Human Services to distribute to nursing facilities an additional amount for wage and benefit increases for direct care workers in nursing homes. The legislature mandated that these funds to be utilized by facilities to provide for increases in wages and benefits for direct care workers especially those that traditionally earn lower wages or are hard to recruit and retain based upon the wage scales paid.

Distribution Methodology: DPHHS will pay Medicaid certified nursing facilities located in Montana who submit an approved request an additional amount, as an add-on to their computed Medicaid payment rate effective July 1, 2000, to be used only for wage and benefit increases for direct care workers in nursing homes. The department will determine a per day add-on payment, commencing July 1, 2000 and at the beginning of each state fiscal year thereafter, as a pro rata share of appropriated funds allocated for increases in direct care wages and benefits. This amount will be in addition to the computed formula rate that is established for each facility on July 1 of the rate year using the formula reimbursement methodology.

Total Funds Add-On: Each facility's pro rata add-on will be computed by dividing the total appropriated funding for direct care wage and benefit increase of $5,859,658 by the total projected Medicaid days for fiscal year 2001 of approximately 1,339,247 to determine the Medicaid per day add-on amount of $4.37 per Medicaid day effective July 1, 2000. The total per day add-on amount is composed of the continuation of the $2.14 that was provided in fiscal year 2000 and the additional amount of $2.23 that is the increased funding that is provided for fiscal year 2001. The annualized amount of funds for each facility will equal $4.37 times the number of projected Medicaid days for FY 2001. The total annualized funding available for each facility is computed in the attached worksheet. The amount that the department determines payable to each facility as specified in this paragraph will be final. No adjustments will be made in the payment amount to account for subsequent changes or adjustments in utilization data or for any other purpose, except that amounts paid are subject to recovery if the facility fails to maintain the required records or to spend the funds in the manner specified in the request.

Request for Funding: To receive the direct care add-on, a nursing facility shall submit for approval a request form to the department which indicates how the total annualized amount of funding attributed to the direct care wage add-on will be spent in the facility. If your facility provided wage increases in fiscal year 2000, the starting wage effective July 1, 2000 should include this increase and the additional funds of $2.23 times the Medicaid days for the facility are the additional direct care wage increases that must be documented for fiscal year 2001. If the facility provided direct care wage incentives or bonuses in fiscal year 2000, the total amount of $4.37 times the Medicaid days must be distributed in fiscal year 2001 to meet the documentation requirements. The facility shall submit all of the information required on this form in order to continue to receive the additional add-on amount for the entire rate year. **Each facility must complete and submit this request form to the Department on or before September 30, 2000.** The request must include all information requested on this form and must meet one of the categories of eligible workers specified below as an appropriate use of these funds. Requests for funding that do not meet one of these criteria/purposes must include a detailed explanation of how the proposed use of the funds meets the purpose of providing for direct care wage or benefit increases. If the Department does not approve a request, it will return the request to the facility with a statement of the reason for disapproval. The facility will then have a limited time within which to provide justification for its proposed use of the funds. Regardless of whether the cost of a proposal approved by the Department exceeds the amount of funds payable to that facility, the Department will not be obligated to and will not reimburse the facility any more than the $2.23/$4.37 per Medicaid day share of the available funding, calculated as described above. Providers that can only document partial use of the $2.23/4.37 add-on will be entitled to keep a pro rata amount of the direct care wage add-on based upon the documentation provided on this form. Any excess funds that have been paid over this amount up to the $2.23/$4.37 will be recovered by the department retroactively in accordance with the recovery provisions outlined below.

Recovery of Funds: A facility that does not submit a qualifying request for use of the funds distributed under this program which includes all of the information that is requested by the department, within the time established by the department, or a facility that does not wish to participate in this additional funding amount shall not be entitled to their share of the funds. The department shall make retroactive adjustment to the payment rate established on July 1, 2000 which will reduce the Medicaid per day payment amount by the $2.23/$4.37 that has been designated for the direct care wage add-on for any nonparticipating or non-qualifying facility. Any amounts paid by the department up to that time for the direct care wage add-on will be recovered by the department.

Records and Documentation: A facility that receives funds under this program must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable Medicaid record requirements, including but not limited to ARM 46.12.308, 46.12.1258 and 46.12.1260.

Direct Care Worker Definition: The categories of workers that will be covered by the direct care wage add-on component may include staff employed as; RN's, LPN's, CNA's, Dietary/Food services, Activities, Social Services, Social Workers, Laundry and Housekeeping. If the request submitted to the department includes a request for other categories of employees other than those listed above please provide detailed information as to why you believe that these staff are appropriate to be included in the distribution of these funds.

effective date. The department will consider wage increases as meeting the legislative intent and documentation requirements for the direct care wage add-on if the wage increase has occurred from the period May 1, 2000 through the end of the state fiscal year 2001 (June 30, 2001). If wage increases occurred prior to May 1, 2000, the department will not consider them as meeting the intent of this distribution and these increases cannot be used as documentation in support of the $2.23 fiscal year 2001 direct care wage funding.

Cost Reporting: Increases in wages and benefits provided by facilities will be allowable and reportable on the Medicaid cost report and will become part of the cost base. The funding for the direct care wage add-on is being provided outside the provider rate increase for this biennium. In the future it will be necessary to remove these costs from the base, if a rebasing occurs, prior to the establishment of payment rates and to continue the funding outside the reimbursement formula process.

Requesting Facility Identifying Information

Facility/Provider Name: _____

Facility Medicaid Provider Number: 31-_____

Facility Certification and Agreement

By signing this request and in consideration for the payment of funds based upon this agreement, the provider/ facility named above ("Provider") represents and agrees as follows:

1. Provider certifies that statements and information included in this agreement are complete, accurate and true to the best of the undersigned facility administrator's or provider's knowledge. The Provider certifies that any funds received on the basis of this request will be used in the manner represented above to provide wage and benefit increases for direct care staff.

2. Provider agrees to the terms and conditions under which this funding is made available, as stated in this form. Provider agrees that it will make, maintain and provide to authorized governmental entities and their agents, records and documentation in accordance with the requirements specified in this agreement.

3. Provider acknowledges and agrees that any funding received on the basis of this agreement and from the legislative appropriation is for the purpose approved, and is to be used for the provision of direct care staff wage or benefits increases. No further payments will be made or provided under this request or from the legislative appropriation for direct care wage add-on funds as described above.

4. Provider understands that payment of funds based upon this request will be from federal and state funds, and that any false claims, statement, or documents, or concealment of material fact, may be prosecuted under applicable federal or state laws. Provider understands that the payment made based upon this application is final, that no adjustments will be made in the payment amount to account for subsequent changes in utilization, appropriation amounts, or for any other purpose, except that amounts paid are subject to recovery in the same manner as other overpayments if the Provider fails to maintain the required records or to use the funds as represented in this agreement.

Signature of Preparer of Form: _____ Date _____, 2000

Signature of Facility Administrator: _____ Date _____, 2000

DPHHS Authorization or Denial Certification

-The provider's request for use of these funds is hereby: Approved _____ Disapproved _____
Comments or reason(s) for disapproval, if applicable: _____

_____

Authorized Signature: _____ Date: _____, 2000
(Signature of DPHHS Official)